THE STATE OF NEW HAMPSHIRE

POINT OF SERVICE MEDICAL
BENEFITS BOOKLET

for Retirees Under Age 65 (Excluding CA Residents)

EFFECTIVE DATE: September 1, 2005

ASO18
3309640

This document printed in December, 2005 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Special Plan Provisions

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

1. You, your dependent or an attending physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
2. The Review Organization assesses each case to determine whether Case Management is appropriate.
3. You or your dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

FPCM6 M

4. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available for example, in-home medical care in lieu of an extended Hospital convalescence. You are not penalized if the alternate treatment program is not followed.
5. The Case Manager arranges for alternate treatment services and supplies, as needed, for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home.
6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed, for example, by helping you to understand a complex medical diagnosis or treatment plan.
7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

FPCM2

Additional Programs

CG may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to employees for the purpose of promoting their general health and well being. Contact CG for details of these programs.

GM6000 PRM1

Notice of Federal Requirements

Coverage for Reconstructive Surgery Following Mastectomy

When a person insured for benefits under this certificate who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

If you have any questions about your benefits under this plan, please call the number on your ID card or contact your employer.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

NOT101

Notice Regarding Provider Directories and Provider Networks

If your Plan utilizes a network of Providers, you will automatically and without charge, receive a separate listing of Participating Providers.

You may also have access to a list of Providers who participate in the network by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider network consists of a group of local medical practitioners, including Hospitals, of varied specialties as well as general practice, who are employed by or contracted with CIGNA HealthCare.

NOT85

Notice of Federal Requirements

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost-effective. This includes premiums for continuation coverage required by federal law.

NOT99

Notice Regarding Emergency Services and Urgent Care

In the event of an Emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a referral from your PCP for Emergency Services, but you need to call your PCP (if you have selected one) or the CIGNA HealthCare 24-hour Health Information Line as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP (if you have selected one) or the CIGNA HealthCare 24-hour Health Information Line will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call 24 hours a day, seven days a week to assist you when you need Emergency Services.

If you receive Emergency Services outside the service area, you must notify the Review Organization as soon as reasonably possible. The Review Organization may arrange to have you transferred to a Participating Provider for continuing or follow-up care, if it is determined to be medically safe to do so.

Urgent Care Inside the Service Area

For Urgent Care inside the service area, you must take all reasonable steps to contact your PCP (if you have selected one) or the CIGNA HealthCare 24-hour Health Information Line for direction and you must receive care from a Participating Provider, unless otherwise authorized by your PCP (if you have selected one) or the Review Organization.

Urgent Care Outside the Service Area

In the event you need Urgent Care while outside the service area, you should, whenever possible, contact your PCP (if you have selected one) or the CIGNA HealthCare 24-hour Health Information Line for direction and authorization prior to receiving services.

Continued or Follow-up Treatment

Continued or follow-up treatment, whether in or out of the service area is not covered unless it is provided or arranged for by your PCP (if you have selected one), a Participating Provider or upon prior authorization by the Review Organization.

GM6000 NOT91 V1

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY THE STATE OF NEW HAMPSHIRE WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "THE STATE OF NEW HAMPSHIRE" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

ASO1 M

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

THE SCHEDULE

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

How to File Your Claim

When you or your Dependents seek care through a Participating Provider, you are only responsible for the applicable copayment, coinsurance or deductible amount shown in the Schedule. You do not need to file a claim form.

If you or your Dependents seek care through a Non-Participating Provider, you must submit a claim form to be reimbursed.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a Benefit Identification Card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

GM6000 CI 3 CLA9V36

Eligibility - Effective Date

Eligibility for Employee Insurance

You will become eligible for insurance on the date you retire if you are in a Class of Eligible Employees.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Classes of Eligible Employees

Each retired employee as reported to the insurance company by your employer, excluding California residents

GM6000 EL 2 V-31
ELI6 M

Employee Insurance

This plan is offered to you as a retired employee, under the age of 65.

Effective Date of Your Insurance

You will become covered on the first of the month following your date of retirement.

To be insured for these benefits, you must elect the insurance for yourself no later than 30 days after your retirement date.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

For your Dependents to be insured, you must elect Dependent Medical Insurance no later than 30 days after the date you become eligible.

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance will become insured for Medical Insurance on the date of his birth, if you elect Dependent Medical Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Exception for Newborn Grandchildren

Any child born to your Dependent child while you are insured for Medical Insurance will be covered for the first 31 days of his life. Coverage for such child will not continue beyond the 31st day and no benefits for expenses incurred beyond the 31st day will be payable.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective on the day of marriage, birth, adoption, or placement for adoption.

GM6000 EF 3 ELI38V5 M

Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage Under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support Order being issued.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

OBRA1

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with States laws regarding child health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

OBRA2

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

When you elect Medical Insurance, you will have an opportunity to select a Primary Care Physician (PCP) for yourself and your Dependents from a list provided by CG. The Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Primary Care Physician's Role/Direct Access to Participating Physicians:

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

However, you and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

GM6000 FLX475 M

Point of Service Medical Benefits

The Schedule

For You and Your Dependents

Point of Service Medical Benefits provide coverage for In-Network and Out-of-Network care. To receive Point of Service Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. For In-Network care, that portion is the Copayment. For Out-of-Network care, that portion is the Deductible or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Out-of-Network portion of the plan.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for the In-Network services rendered. Deductibles, applicable to Out-of-Network care, are also expenses to be paid by you or your Dependent. Deductible amounts are separate from, and not reduced by, Copayments. Copayments and Deductibles are in addtion to any Coinsurance.

If you are unable to locate an In-Network provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your benefit identification card to obtain authorization for Out-of-Network provider coverage. If you obtain authorization for services provided by an Out-of-Network provider, benefits for those services will be paid at the In-Network benefit level.

Self-Referral

Self-referral occurs when a person chooses to seek care or treatment from an In-Network provider without obtaining a referral from his Primary Care Physician. Benefits payable for Covered Expenses incurred for self-referred Physician or Inpatient Services will be determined by the In-Network provider in accordance with The Schedule below.

Guest Privileges

If you or one or your Dependents will be residing temporarily in another location where there is a network of Participating Providers, you may be eligible for Point of Service Medical Benefits at that location. However, the benefits available at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your employer for more information.

Benefits	This Plan will Pay:	
	In-Network	Out-of-Network
Lifetime Maximum Benefit	Unlimited	

Deductibles	You Pay: In-Network (with PCP Referral)	In-Network (Self-Referral)	Out-of-Network
Calendar Year Deductibles			
Deductibles are expenses to be paid by an employee or Dependent for the services rendered Out-of-Network. These Deductibles are in addition to any Coinsurance.			
Individual Deductible	None	None	$150 per person
Family Deductible	None	None	$450 per family
After Out-of-Network Medical Deductible amounts totaling $450 have been applied in a calendar year for either: (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Out-of-Network Medical Deductible amounts for the rest of that calendar year.			

	In-Network (with PCP Referral)	In-Network (with Self-Referral)	Out-of-Network
Out-of-Pocket Expenses			
Out-of-Pocket Expenses are Covered Expenses incurred for charges made by: (a) Participating Providers (when self-referred); or (b) non-Participating Providers, for which no payment is provided because of the coinsurance facor. However, any expenses incurred due to non-compliance penalties or charges in excess of Reasonable and Customary levels will not accumulate toward the Out-of-Pocket Maximums.			
Individual Out-of-Pocket Maximums	None	$600 per person	$900 per person
Family Out-of-Pocket Maximums	None	$1,800 per family	$2,700 per family
After Out-of-Pocket Expenses totaling to the amounts shown in the table above have been incurred in a calendar year for either: (a) you and your Dependents; or (b) your Dependents, your family need not satisfy any further Out-of-Pocket Expenses for the rest of that calendar year.			

Benefits	How This Plan Works:		
	In-Network (with PCP Referral)	**In-Network (with Self-Referral)**	**Out-of-Network**
For care other than for Mental Health and Substance Abuse	You or your Dependent pays the Copayments below, then the Plan pays the Benefit Percentage shown.	You or your Dependent pays the Copayment or Coinsurance below, then the Plan pays the Benefit Percentage shown.	You or your Dependent pays the Out-of-Network Deductible plus any Coinsurance below, then the Plan pays the Benefit Percentage shown.
Physician Services			
Physician Office Visit	$10 copay, then 100%	$30 copay, then 100%	80%, after plan deductible
Specialty Care Physician Office Visit	$10 copay, then 100%	$30 copay, then 100%	80%, after plan deductible
Surgery Performed in the Physician's Office	$10 copay, then 100%	$30 copay, then 100%	80%, after plan deductible
Surgery Performed in the Specialist's Office	$10 copay, then 100%	$30 copay, then 100%	80%, after plan deductible
Allergy Treatment/ Injections	$10 copay, then 100%	$30 copay, then 100%	80%, after plan deductible
Allergy Serum (dispensed by the Physician in the office)	No Charge	No Charge	80%, after plan deductible
Preventive Care			
Well-Child Care (including vision and hearing screenings) through age 18	$10 per visit, then 100%	$30 per visit, then 100%	80% after plan deductible
Child Immunizations	No Charge	No Charge	No Charge

Annual Routine Physicals for persons aged 19 and older	$10 per visit, then 100%	$30 per visit, then 100%	80% after plan deductible
Adult Immunizations	No Charge	No Charge	No Charge
Well-Woman Exam Calendar Year Maximum: 1 visit	No Charge	No Charge	No Charge
Complete Vision Care Examination	$10 per examination, then 100%	$10 per examination, then 100%	80%, after plan deductible
Vision Benefit Maximum: For persons under age 19: 1 per calendar year For persons 19 or older: 1 every 2 calendar years			
Pap Test	No Charge	No Charge	No Charge
Mammogram	No Charge	No Charge	No Charge
Prostate Specific Antigen (PSA)	No Charge	No Charge	No Charge
Pre-Admission Testing			
Primary Care Physician Office Visit	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Specialist Physician Office Visit	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Outpatient Facility	No charge for X-Ray/Lab if billed by a separate outpatient diagnostic facility	No charge for X-Ray/Lab if billed by a separate outpatient diagnostic facility	80% after plan deductible

Inpatient Hospital - Facility Services **Covered Expense Daily Limit**	No Charge	20% (Plan pays 80%)	80% after plan deductible
Semi Private Room and Board	The Hospital's negotiated rate	The Hospital's negotiated rate	The Hospital's most common daily rate for a semi-private room
Private Room	The Hospital's negotiated rate for a semi-private room	The Hospital's negotiated rate for a semi-private room	The Hospital's most common daily rate for a semi-private room
Special Care Units (ICU/CCU)	The Hospital's negotiated rate for an ICU/CCU room	The Hospital's negotiated rate for an ICU/CCU room	The Hospital's most common daily rate for an ICU/CCU room
Outpatient Surgical Facility Services Operating Room, Recovery Room, Procedure Room, and Treatment	No Charge	20% (Plan pays 80%)	80% after plan deductible

Second Opinions (Services will be provided on a voluntary basis)			
Primary Care Physician Office Visit	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Specialist Physician Office Visit	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Outpatient Facility	No Charge	No Charge	80% after plan deductible

Inpatient Hospital Doctor's Visits/Consultations	No Charge	20% (Plan pays 80%)	80% after plan deductible
Inpatient Hospital Professional Services: Surgeon Radiologist Pathologist Anesthesiologist	No Charge	20% (Plan pays 80%)	80% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	No Charge	20% (Plan pays 80%)	80% after plan deductible

Emergency and Urgent Care Services			
Physician's Office	$10 copay, then 100%	$10 copay, then 100%	$10 copay, then 100%*
Specialist's Office	$10 copay, then 100%	$10 copay, then 100%	$10 copay, then 100%*
Hospital Emergency Room	$10 per visit, then 100%* (waived if admitted)	$10 per visit, then 100%* (waived if admitted)	$10 per visit, then 100%* (waived if admitted)
Urgent Care Facility or Outpatient Facility	$10 per visit, then 100%* (waived if admitted)	$10 per visit, then 100%* (waived if admitted)	$10 per visit, then 100%* (waived if admitted)
Ambulance	No Charge *	No Charge *	No Charge *
* *If not a true emergency, services are not covered.*			

Inpatient Services at Other Health Care Facilities Includes: Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 100 Days	No Charge	20% (Plan pays 80%)	80% after plan deductible

Laboratory and Radiology Services			
MRIs, MRAs, CAT Scans and PET Scans	No Charge	20% (Plan pays 80%)	80% after plan deductible
Other Laboratory and Radiology Services (All charges billed by an independent facility)	No Charge	No Charge	80% after plan deductible

Outpatient Short-Term Rehabilitative Therapy	No Charge	20% (Plan pays 80%)	80% after plan deductible
	Calendar Year Maximum: Unlimited	Calendar Year Maximum: $3,000	Calendar Year Maximum: $3,000
Includes: Cardiac Rehab Pulmonary Rehab Physical Therapy Speech Therapy Occupational Therapy Cognitive Therapy			
Chiropractic Care	$10 per visit, then 100%	$10 per visit, then 100%	80% after plan deductible
Calendar Year Maximum: 12 Visits			

Home Health Care	No Charge	20% (Plan pays 80%)	80% after plan deductible
Calendar Year Maximum: Unlimited			

Hospice			
Inpatient	No Charge	20% (Plan pays 80%)	80% after plan deductible
Outpatient	No Charge	20% (Plan pays 80%)	80% after plan deductible

Bereavement Counseling	No Charge	20% (Plan pays 80%)	Not Covered

Maternity			
Initial Visit to Confirm Pregnancy	$10 copay, then 100%	$10 copay, then 100%	80% after plan deductible
All Subsequent Prenatal Visits, Postnatal Visits, and Delivery	No Charge	No Charge	80% after plan deductible
Delivery (Inpatient Hospital, Birthing Center)	No Charge	No Charge	80% after plan deductible

Abortion (Includes elective and non-elective procedures)			
Inpatient	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Surgical Facility	Same as plan's Outpatient Facility Services Benefit	Same as plan's Outpatient Facility Services Benefit	Same as plan's Outpatient Facility Services Benefit
Physician's Services	No Charge	20% (Plan pays 80%)	80% after plan deductible

Family Planning			
Office Visits including Tests and Counseling	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible

Family Planning (cont.)			
Surgical Sterilization Procedures for vasectomy/ Tubal Ligations (excluding reversals)			
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Facility Services Benefit	Same as plan's Outpatient Facility Services Benefit	Same as plan's Outpatient Facility Services Benefit
Physician's Services	No Charge	20% (Plan pays 80%)	80% after plan deductible

Infertility Treatment			
Office Visit (Tests, Counseling)	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Surgical Treatment: Includes procedures for Correction of Infertility, In Vitro Fertilization, Artificial Insemination, GIFT, ZIFT, etc.			
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Same as plan's Inpatient Hospital Facility benefit	80% after plan deductible
Outpatient Facility	Same as plan's Outpatient Facility Services benefit	Same as plan's Outpatient Facility Services benefit	80% after plan deductible
Physician's Services	No Charge	20% (Plan pays 80%)	80% after plan deductible
Lifetime Maximum: Unlimited			

Organ Transplants Includes all medically appropriate non-experimental transplants			
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Same as plan's Inpatient Hospital Facility benefit	Same as plan's Inpatient Hospital Facility benefit
Physician's Services	No Charge	20% (Plan pays 80%)	80% after plan deductible
Travel Services Maximum (Covered only when transplant procedure is performed at a Lifesource Facility)	$10,000 per procedure	Not Covered	Not Covered

Durable Medical Equipment/External Prosthetic Appliances Calendar Year Maximum: Unlimited	No Charge	20% (Plan pays 80%)	80%, after combined $150 DME/EPA benefit deductible

Hearing Aids (for persons through age 18)	No Charge	No Charge	80%, after plan deductible

Oral Surgical Procedures	$10 copay, then 100%	$30 copay, then 100%	80%, after plan deductible

Dental Care (Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth)			
Office Visits	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit
Physician's Services	No Charge	20% (Plan pays 80%)	80% after plan deductible

Temporomandibular Joint Disorder (Surgical & Non-Surgical Treatment)			
Office Visit	$10 copay, then 100%	$30 copay, then 100%	80% after plan deductible
Inpatient Facility	No Charge	20% (Plan pays 80%)	80% after plan deductible
Outpatient Facility	No Charge	20% (Plan pays 80%)	80% after plan deductible
Physician's Services	No Charge	20% (Plan pays 80%)	80% after plan deductible

	How This Plan Works:		
	In-Network (with PCP Referral)	**In-Network (with Self-Referral)**	**Out-of-Network**
For Mental Health and Substance Abuse Treatment	You or your Dependent pays the Copayments below, then the Plan pays the Benefit Percentage shown.	You or your Dependent pays the Copayment or Coinsurance below, then the Plan pays the Benefit Percentage shown.	You or your Dependent pays the Out-of-Network Deductible plus any Coinsurance below, then the Plan pays the Benefit Percentage shown.
Mental Health			
Inpatient	No Charge	No Charge	80% after plan deductible
Calendar Year Maximum: Unlimited			
Mental Health Outpatient (Individual or Group Therapy)	$10 per visit, then 100%	$10 per visit, then 100%	80% after plan deductible
Calendar Year Maximum: Unlimited			
Substance Abuse			
Inpatient	No Charge	No Charge	80% after plan deductible
Calendar Year Maximum: The lesser of: (a) 30 days; or (b) $3,000 *			

Outpatient (Individual or Group Therapy) Calendar Year Maximum: $3,000 ***** *** Combined Substance Abuse Maximums (Inpatient and Outpatient)** Per Calendar Year: $3,000 Lifetime: $10,000	$10 per visit, then 100%	$10 per visit, then 100%	80% after plan deductible

Point of Service Medical Benefits

For You and Your Dependents

Certification Requirements - Out-of-Network

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for the treatment of Substance Abuse in an Intensive Outpatient Therapy Program.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital:

- unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

GM6000 PAC1 V33 DG M

PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

GM6000 PAC2 V9

Outpatient Certification Requirements - Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which CG has contracted. Outpatient Certification should be only requested for nonemergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will be reduced by 50% for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

Advanced radiological imaging - CT Scans, MRI, MRA or PET scans

Hysterectomy

GM6000 SC1 PAC4 OCR8V5 DG

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- for outpatient Mental Health and Substance Abuse services;
- advanced radiological imaging;
- outpatient facility services;
- nonemergency ambulance; or
- transplant services.

GM6000 05BPT16 V6 DG M

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CG. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

GM6000 CM5 FLX107V126

- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.

GM6000 CM6 FLX108V748 DG

- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- charges made for Routine Preventive Care, including immunizations. Routine Preventive Care means health care assessments, wellness visits and any related services.

GM6000 CM6 FLX108V770 DG

- charges for or in connection with mammograms for breast cancer screening or diagnostic purposes not to exceed: (a) one baseline low-dose mammogram for women ages 35 to 39 years of age; (b) a mammogram every one to two years for women 40 to 49 years of age, even if no symptoms are present; and (c) one annual mammogram for women age 50 and over.
- charges for the treatment of cancer by autologous bone marrow transplants, which follows the protocols reviewed and approved by the National Cancer Institute.
- charges for nonprescription enteral formulas and food products for the treatment of impaired absorption of nutrients caused by disorders of the gastrointestinal tract or inherited diseases of amino or organic acids. The Physician must issue a written order stating the enteral formula or food product is needed to sustain life, in the case of malabsorption; medically necessary; and the least restrictive and most cost-effective means for meeting the

needs of the insured. Coverage for inherited diseases of amino and organic acids will be subject to an annual maximum of $1,800.

- charges for 48 hours inpatient stay following a vaginal delivery or 96 hours following a cesarian section. An earlier discharge may be determined by the mother and attending Physician. An additional length of stay will be covered if deemed medically necessary.

  If discharge is prior to the 48/96 hours, at least 2 postpartum visits will be provided if the service is by a licensed Physician with experience in perinatal care.

- charges for Medically Necessary prenatal and/or postpartum homemaker services when a woman is confined to bed rest or her daily activities are restricted by her provider.
- charges made for surgical and nonsurgical care of Temporomandibular Joint Dysfunction (TMJ), excluding appliances and orthodontic treatment.
- charges for the cost of biologicals that are immunizations or medications for the purpose of travel.
- charges made for or in connection with an eye examination, not to exceed the maximums shown in The Schedule.
- charges made for the initial purchase and fitting of external prosthetic devices which are used as replacements or substitutes for missing body parts and are necessary to alleviate or correct Sickness, Injury or congenital defect; including only artificial arms and legs and terminal devices such as hands or hooks. Replacement of such prostheses is covered only if needed due to normal anatomical growth.
- charges made for hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
-

GM6000 CM65 INDEM145V19 M

- charges made by a Hospital or Ambulatory Surgical Facility for general anesthesia administered by a licensed anesthesiologist or anesthetist for dental procedures for: (a) a child under the age of 6 who is determined by a licensed dentist in conjunction with a licensed Physician to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in an Ambulatory Surgical Facility or Hospital setting; or (b) an individual with a developmental disability or exceptional medical circumstances, as determined by a licensed Physician, which place the person at serious risk.
- charges made for treatment of Biologically-Based Mental Illness, including: schizophrenia and other psychotic disorders; schizoaffective disorder; major depressive disorder; bipolar disorder; anorexia nervosa and bulimia nervosa; obsessive-compulsive disorder; panic disorder; pervasive developmental disorder or autism; or chronic post-traumatic stress disorder. Such Covered Expenses will be payable the same as for other illnesses. Any exceptions or limitations for mental illness shown in The Schedule will not apply to Biologically-Based Mental Illness.

GM6000 CM6 INDEM146V16

- charges for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia including the treatment of breast cancer by autologous bone marrow transplants, or permanent loss of scalp hair due to injury, upon written recommendation of a Physician. Coverage for alopecia medicamentosa will be limited to $350 per year. Scalp hair prostheses means artificial substitutes for scalp hair that are made for a specific individual.
- charges for a drug that has been prescribed for a specific indication for which use of the drug has not been approved by the U.S. Food and Drug Administration (U.S. FDA). Such drugs will be covered if: (a) the drug is recognized for treatment of the specific indication in one of the standard reference compendia or in medical literature as recommended by the American Medical Association: (b) it has been otherwise approved by the FDA; and (c) it has not been contraindicated by the U.S. FDA for the use prescribed. Coverage will also be provided for any medical services necessary to administer the drug.

GM6000 INDEM147V8

The following benefits will apply to insulin and noninsulin-dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for Durable Medical Equipment, including podiatric appliances, related to diabetes. A special maximum will not apply.
- charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
  - (a) medically necessary visits when diabetes is diagnosed;
  - (b) visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;

- (c) visits when reeducation or refresher training is prescribed by the Physician; and
- (d) medical nutrition therapy related to diabetes management.

GM6000 INDEM148V11

Genetic Testing

- charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
  - a person has symptoms or signs of a genetically-linked inheritable disease;
  - it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

GM6000 05BPT1 V8

  - the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per contract year for both pre- and post- genetic testing.

Nutritional Evaluation

- charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances

- charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

GM6000 05BPT2 V1

Clinical Trials for Treatment Studies on Cancer and Life-threatening Conditions

Coverage will be provided for all Medically Necessary routine patient care costs incurred as a result of treatment being provided in accordance with a clinical trial, to the extent such costs would be covered for noninvestigational treatments if the treatment is being provided or the studies are being conducted in a phase I, phase II, phase III, or phase IV clinical trial for cancer or the treatment is being provided for any other life-threatening condition. Coverage for phase I or phase II clinical trials shall be decided on a case by case basis.

Coverage is required if:

(1) the treatment is being provided to the insured in a clinical trial approved by:
  (a) one of the National Institutes of Health;
  (b) an NIH cooperative group or an NIH center;
  (c) the FDA in the form of an investigational new drug application or exemption;
  (d) the federal department of Veterans Affairs or Defense; or
  (e) an institutional review board of an institution in New Hampshire that has a multiple assurance contract approved by the Office of Protection from Research Risks of the NIH;

(2) standard treatment has been or would be ineffective, does not exist, or there is no superior noninvestigational treatment alternative;

(3) the facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treatment to maintain expertise; and

(4) the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

Coverage will be provided for routine patient care costs incurred for drugs and devices provided to the insured during the clinical trial, which are not the subject of the clinical trial, provided that those drugs or devices have been approved for sale by the FDA, whether or not the FDA has approved the drug or device for use in treating the insured's particular condition. This coverage includes reasonable and Medically Necessary services necessary to administer the drug or use the device under evaluation in the clinical trial.

GM6000 INDEM193

Home Health Care Services

charges made for Home Health Care Services when you:

- require skilled care;

- are unable to obtain the required care as an ambulatory outpatient; and
- do not require confinement in a Hospital or Other Health Care Facility.

Home Health Care Services are provided under the terms of a Home Health Care plan for the person named in that plan.

If you are a minor or an adult who is dependent upon others for nonskilled care (e.g. bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your nonskilled care needs.

Home Health Care Services are those skilled health care services that can be provided during intermittent visits of two hours or less by Other Health Care Professionals. Necessary consumable medical supplies, home infusion therapy, and Durable Medical Equipment administered or used by Other Health Care Professionals in providing Home Health Care Services are covered. Home Health Care Services do not include services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-Term Rehabilitative Therapy."

GM6000 INDEM2 V16

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Daily Limit shown in The Schedule;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;

GM6000 CM34 FLX124V26

  - physical, occupational and speech therapy;
  - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living.

GM6000 CM35 FLX124V27

Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services includes Partial Hospitalization.

Inpatient Mental Health services are exchangeable with Partial Hospitalization sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

GM6000 INDEM9 V51 M

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week. Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health services at a rate of one visit of Mental Health Intensive Outpatient Therapy being equal to one visit of Outpatient Mental Health Services.

GM6000 INDEM10 V46 M

Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse of or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services includes Partial Hospitalization sessions.

Inpatient Substance Abuse services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week. Substance Abuse Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Abuse services at a rate of one visit of Substance Abuse Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Abuse Rehabilitation Services.

GM6000 INDEM11 V62 M

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. CG will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Mental Health and Substance Abuse Residential Treatment.
- Custodial care, including but not limited to geriatric day care.

- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

GM6000 INDEM12 V48 DG M

Durable Medical Equipment

- charges made for the purchase or rental of Durable Medical Equipment which is ordered or prescribed by a provider and provided by a vendor approved by CG. Coverage for the repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to growth or a change in medical condition.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of Injury or Sickness, are appropriate for use in the home, and are not disposable. Such equipment includes, but is not limited to: crutches, Hospital beds, wheel chairs, respirators, and dialysis machines.

Unless covered in connection with the services described in another section of this certificate, the following are specifically excluded:

- Hygienic or self-help items or equipment;
- Items or equipment that are primarily used for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
- Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
- Institutional equipment, such as air fluidized beds and diathermy machines;
- Wigs;
- Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, orthotics, braces and splints;
- Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
- Items which under normal use would constitute a fixture to real property, such as ramps, railings, and grab bars.

Coverage is subject to the maximum shown in The Schedule.

GM6000 INDEM1 V4 M

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician, approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded infertility services:

- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Donor charges and services;
- Cryopreservation of donor sperm and eggs; and
- Any experimental, investigational or unproven infertility procedures or therapies.

GM6000 05BPT6 V1

Short-Term Rehabilitative Therapy

charges made for **Short-Term Rehabilitative Therapy** which is a part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate inpatient or outpatient setting.

The following limitations apply to Short-Term Rehabilitative Therapy Services:

- Occupational therapy is provided only for purposes of training members to perform the activities of daily living.
- Speech therapy is not covered when (a) used to improve speech skills that have not fully developed; (b) considered custodial or educational; (c) intended to maintain speech communication; or (d) not restorative in nature.

- Multiple services provided on the same day constitute one visit, but a separate Copayment will apply to the services provided by each Physician.

GM6000 INDEM8 V30

Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

You do not need a referral from your Primary Care Physician.

The following limitations apply to Chiropractic Care Services:

- To be covered, all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- Services are not covered if they are considered custodial, training, developmental or educational in nature.
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.
- Services of a chiropractor which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- Vitamin therapy;
- Massage therapy in the absence of other modalities.

GM6000 05BPT10

Transplant Services

- charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel, liver or multiple viscera.

All Transplant services received from non-Participating Providers are payable at the Out-of-Network level.

All Transplant services, other than cornea, must be received at a CIGNA LIFESOURCE Transplant Network® facility. Cornea transplants are payable when received from Participating Provider facilities other than CIGNA LIFESOURCE Transplant Network® facilities.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses:

travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or

tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

GM6000 05BPT7 V7 DG M

Breast Reconstruction and Breast Prostheses

Charges made for reconstructive surgery following a mastectomy, if the insured chooses to have surgery, and in the manner chosen by the insured and Physician. Services and benefits include:

- surgical services for reconstruction of the breast on which surgery was performed;
- surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance;
- postoperative breast prostheses; and
- mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy are covered.

Cosmetic Surgery

Charges made for cosmetic surgery or therapy to repair or correct severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw or TMJ disorder), tumors, trauma, disease or the complications of Medically Necessary non-cosmetic surgery.

Reconstructive surgery for correction of congenital birth defects or developmental abnormalities must be performed prior to your attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by CG.

•

GM6000 INDEM13 V12

Exclusions, Expenses Not Covered and General Limitations

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- the following services are excluded unless Medically Necessary: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; and orthognathic surgeries;
- the following services are excluded from coverage regardless of clinical indications: redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery, or (d) charges made by a Physician for any of the following Surgical Procedures:

  - surgical removal of bone impacted teeth;
  - for the surgical procedure (excluding charges for related preoperative or post operative care, including medical, lab and x-ray benefits);
  - for intravenous sedation furnished by the operating dentist or oral surgeon;
  - for anesthesia furnished by an anesthesiologist who is not the operating dentist or oral surgeon; and
  - gingivectomy is limited to the excision of the soft tissue wall of the "pocket" up to four quadrants per lifetime.

  No benefits will be available for x-rays of teeth, local anesthesia services by the surgeon, surgical exposure, osseous and flap procedures in conjunction with gingivectomy and other services for periodontal disease.
- for medical and surgical services intended primarily for the treatment or control of obesity, which are not Medically Necessary. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass.

- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- for treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- for nonmedical ancillary services, including but not limited to vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities or developmental delays, autism or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies, including but not limited to: bandages and other disposable medical supplies, skin preparations and test strips.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision unless determined by the utilization review Physician to be Medically Necessary.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- charges made for hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs) for persons above age 18. A hearing aid is any device that amplifies sound.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, garter belts, corsets, dentures and wigs.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- charges made for or in connection with routine refractions except as specifically provided under your medical plan, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- all noninjectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or preimplantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent,

when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.

- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

GM6000 05BPT14 V126 DG M

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical or dental care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.

(2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.

(3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

GM6000 COB11

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

(1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

(2) If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.

(3) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

(4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

(5) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

GM6000 COB12

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

(1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

(2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

(a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

(b) then, the Plan of the parent with custody of the child;

(c) then, the Plan of the spouse of the parent with custody of the child;

(d) then, the Plan of the parent not having custody of the child, and

(e) finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13

(4) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

Rules for Coordination with Medicare

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of this Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred percent (100%) of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. CG will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

GM6000 COB14V3

As each claim is submitted, CG will determine the following:

(1) CG's obligation to provide services and supplies under this policy;

(2) whether a benefit reserve has been recorded for you; and

(3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, CG will use the benefit reserve recorded for you to pay up to one hundred percent (100%) of

the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If CG pays charges for benefits that should have been paid by the Primary Plan, or if CG pays charges in excess of those for which we are obligated to provide under the Policy, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CG will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CG, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

GM6000 COB15

Medicare Eligibles

CG will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

(a) a former employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) a retired employee or retired employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

GM6000 MEL23V4 M

CG will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any former employee and his Dependent unless he is listed under (a) through (c) above.

GM6000 MEL45V2

Right of Reimbursement

The Policy does not cover:

(1) Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).

(2) Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care Expenses as described in (1) and (2) above, Connecticut General shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Policy. You or your Dependent(s) or their representative shall execute such

documents as may be required to secure Connecticut General's rights. Connecticut General shall be reimbursed the lesser of:

the amount actually paid by CG (or the HealthPlan) under the Policy; or

an amount actually received from the third party;

at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

GM6000 CCP1 CCL1V4

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by CG. CG may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

CG, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- The methodologies in the most recent edition of the Current Procedural terminology.
- The methodologies as reported by generally recognized professionals or publications.

GM6000 TRM366

Termination of Insurance

Termination of Insurance - Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.

Any continuation of insurance must be based on a plan which precludes individual selection.

GM6000 TER1 V-103
TRM23V3 DG M

Termination of Insurance - Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

GM6000 TRM62

Special Continuation of Medical Insurance - Dependent

If health insurance for your Dependents would otherwise cease because of: (1) your death; (2) your entitlement to Medicare; (3) divorce or legal separation; or (4) with respect to a Dependent child, failure to continue to qualify as a Dependent, Medical insurance may be continued upon payment of the required premium to the employer. It will continue until the earliest of:

For a spouse who is under age 55:

- 36 months from the date of (1), (2), (3) or (4) above, whichever may occur first;
- the last day for which the required premium has been paid;
- the date the Dependent becomes entitled to Medicare;
- the first day of the month following the date the Dependent becomes covered under another group health plan;
- the date the policy is cancelled.

For a spouse who is age 55 or over:

- the first day of the month following the date your former spouse becomes eligible for coverage under another group health plan;
- for a Dependent child who reaches the limiting age during the continuation period, 36 months from the date of the employee's death or divorce;
- the date your former spouse becomes eligible for Medicare;
- the last day for which the required premium has been paid;
- the date the policy is cancelled.

Notification and Election

Your employer should notify you of your right to continue insurance within 15 days after termination. You and your Dependents must submit an application and first premium payment no later than 31 days after notice was sent.

GM6000 TRM111 V16

Special Continuation of Medical Insurance

If group medical coverage for you or your Dependents is cancelled for any reason, coverage may be continued from the date of cancellation until the earliest of the following:

- 39 weeks from the date group coverage is cancelled;
- the date the person fails to make a timely premium payment;
- the date the person becomes eligible for benefits under another group plan or under Medicare; or
- the date your Dependent ceases to qualify as a Dependent under the provisions of the plan.

Notification and Election

You and your Dependents must submit an application and first premium payment no later than 31 days after the date the group plan terminates. If CG does not notify you or your Dependents within 15 days after the date the group plan terminates, the application period will be extended to the earlier of: (a) 15 days after notice is received; or (b) 6 months from the date the person's original 31-day application period expired. If coverage for you and your Dependents ends because CG does not provide required notice of continuation, CG will be liable for any benefits payable during the lapse in coverage.

Interaction with Other Continuation

If coverage for you or your Dependents is being continued as provided under federal law, and the group plan is cancelled before the continuation period expires, the person will be eligible for continued coverage as described above.

Conversion

Upon cancellation of the group plan, you or your Dependents may elect to continue coverage as described above or to convert coverage as described in the section of this certificate entitled "Conversion Privilege". If extended coverage is elected, converted coverage may be elected when extended coverage ends.

GM6000TER6 TRM109V2

Special Continuation of Life and Medical Insurance - Strike

If your Active Service ends due to strike, your insurance will be continued until the earliest of:

a) 6 months past the date your active service ends;

b) the date you fail to make a timely premium payment; or

c) the date you become eligible for insurance under another group policy for medical benefits or Medicare.

Medical benefits only may be continued for an additional 6 months in accordance with federal law.

GM6000 TRM111 V12

Continuation Required by Federal Law For Your Dependents

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your employer's group health plan(s) and is subject to federal law, regulations and interpretations.

COBRA13 M

Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the employer. In the case of (2) or (3) above, you or your Dependent must notify your employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

COBRA14 M

If you retire within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If you retire more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date you retire.

COBRA4 M

Effect of Employer Chapter 11 Proceedings on Retiree Coverage

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceeding, coverage will continue until: a. for you, your death; and b. for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

COBRA15 M

Payment of Premium

This Plan may require the payment of an amount that does not exceed 102% of the applicable premium, except this Plan may require payment of up to 150% of the Applicable Premium for any extended period of continuation coverage for a covered person who is disabled. The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.

Applicable Premium is determined as follows:

1. if the retiree alone elects to continue coverage, the retiree will be charged the active employee rate;
2. if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active employee rate;
3. if a Dependent child or children elect to continue coverage without a parent also electing the continuation, each child will be charged the active employee rate;
4. if the entire family elects to continue coverage, they will be charged the family rate;
5. if the Schedule of Premium rates is set up on a step-rate basis, the active rate basis that fits the individuals who elect to continue their coverage is the rate that will be charged. If only children elect to continue coverage, each child will be charged the employee Only rate.

Timely Payment

If Payment is made within the grace period in an amount not significantly less than the amount the Plan requires to be paid, the amount must be deemed to satisfy the Plan's requirement. However, you must be notified and allowed at least 30 days after notice is provided for payment to be made.

Providing Notification of Your Status to Health Care Providers During the Grace Period

If, after you elect to continue coverage, a health care provider contacts this Plan to confirm coverage for a period for which premium has not yet been received, the Plan must give a complete and accurate response.

COBRA17 M

Notification Requirements

Your employer should send you initial notification of coverage continuation rights as required by federal law; (a) when the Plan first becomes subject to federal continuation requirements; (b) when you are hired; and (c) when you add a

spouse as a Dependent for benefits under the Plan. Receipt of this certificate may serve as such notice.

If you become eligible to continue coverage per federal law, your employer must send you notification within 14 days. If the Plan has a Plan Administrator, the employer must notify the Plan Administrator within 30 days. The Plan Administrator must notify you within 14 days, thereafter.

If eligibility to continue coverage is due to divorce, legal separation or a Dependent child losing eligibility for coverage under the Plan, you or your Dependent spouse must notify your employer within 60 days of such event. Your employer must notify you of the right to continue coverage within 14 days after receipt of notification of such event.

COBRA18 M

Conversion Available Following Continuation

If you or your Dependent's Continuation ends due to the expiration of the maximum 18-, 29- or 36-month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to employees and their Dependents.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events (1) or (2) in the section entitled “Dependent Continuation Provision” should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

COBRA5 M

Benefits Extension

Medical Benefits Extension Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury or Sickness, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group policy;
- the date you are no longer Totally Disabled;
- 12 months from the date your Medical Benefits cease; or
- 12 months from the date the policy is cancelled.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness, you are unable to engage in the normal activities of a person of the same age, sex, and ability.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

GM6000 BEX183 V8 M

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You can also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CG within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CG to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

GM6000 APL257

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one appeal.

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level-two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

GM6000 APL258

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG's level two appeal review denial. CG will then forward the file to the Independent Review organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by CG's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CG.

GM6000 APL261

Definitions

Active Service

You will be considered in Active Service:

- on any of your employer's scheduled work days if you are performing the regular duties of your work on a full-time or part-time basis on that day either at your employer's place of business or at some location to which you are required to travel for your employer's business;
- on a day which is not one of your employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

DFS1 M

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

DFS14

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CG for a different amount.

DFS940

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can usually be self-administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

DFS1812

Dependent

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 19 years old;
  - 19 years but less than 25 years old, enrolled in school as a full-time student and primarily supported by you. Proof of the child's age, status as a student and dependence must be submitted to CG as of the later of his 19th birthday or the date he is enrolled for Dependent Insurance. After that, CG may require such proof at least once each year until he attains age 25.
  - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child, including that child from the first day of placement in your home. However, if your petition of adoption is withdrawn or dismissed, coverage for the child will be terminated.

A child also includes a stepchild who lives with you and a child for whom you are the legal guardian.

Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one employee.

DFS951 DG M

Emergency Service/Emergency Medical Condition

Emergency Services are covered inpatient and outpatient services that are furnished by a qualified provider and are needed to evaluate or stabilize an Emergency Medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would result in one of the following:

(1) Placing the health of the individual, or with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;

(2) Serious impairment to bodily function; or

(3) Serious dysfunction of any bodily organ or part.

DFS1548

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

DFS60

Free-Standing Surgical Facility

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

DFS682

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

DFS70

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

DFS599

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CG; and
- fulfills any licensing requirements of the state or locality in which it operates.

DFS72

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

DFS1693

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;

DFS1815 M

Injury

The term Injury means an accidental bodily injury.

DFS147

In-Network/Out-of-Network

The term In-Network refers to healthcare services or items provided by your Primary Care Physician or services/items provided by another Participating Provider and authorized by your Primary Care Physician or the Review Organization. Authorization by your Primary Care Physician or the Review Organization is not required in the case of Mental Health and Substance Abuse treatment, other than Hospital Confinement solely for detoxification.

The term Out-of-Network refers to care which does not qualify as In-Network.

Emergency Care which meets the definition of Emergency Services and is authorized as such by either the Primary Care Physician or the Review Organization is considered In-Network. (For details, refer to the Emergency Services and Urgent Care coverage section.)

DFS1694

Maximum Reimbursable Charge

The Maximum Reimbursable Charge is the lesser of:

1. the provider's normal charge for a similar service or supply; or
2. The State of New Hampshire's-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered.

CG uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

The State of New Hampshire's-selected percentile used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services/Customer Service.

Additional information about the Maximum Reimbursable Charge is available upon request.

DFS1814 M

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

DFS192

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are:

- required to diagnose or treat an illness, injury, disease or its symptoms; and
- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration; and
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

DFS1908

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

DFS149

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

DFS285

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

DFS155

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or a Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

DFS1686

Other Health Care Professional

The term Other Health Care Professional means an individual, other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Care Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

DFS1685

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with CIGNA to provide covered services with regard to a particular plan under which the participant is covered.

DFS1910

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

DFS164

Primary Care Physician

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.

DFS622

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include: (1) any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is: (a) operating within the scope of his license; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist; and (2) any psychotherapist while he is providing care authorized by the Provider Organization if he is: (a) state licensed or nationally certified by his professional discipline; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist.

DFS585

Review Organization

The term Review Organization refers to an affiliate of CG or another entity to which CG has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

DFS1688

Self-Referral

Self-referral occurs when a person chooses to seek care or treatment from an In-Network provider without obtaining a referral from his Primary Care Physician. Benefits payable for Covered Expenses incurred for self-referred Physician or Inpatient Services will be determined by the In-Network provider in accordance with The Schedule.

Sickness - For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

DFS531

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

Specialist Physician

The term Specialist Physician means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine or pediatrics.

DFS1638

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

DFS197

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by CG, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

DFS1534

DEF